Form PWI 06
Revised 8/99

# TARGETED CASE MANAGEMENT FOR PREGNANT WOMEN AND INFANTS REASSESSMENT FORM

NAME:_____ DOB: _____
Reassessment With The Client Once During: Pregnancy _____(Gestational Age) Infants First Year _____(Age)
Completed Face to Face: Yes_____ No_____
If no, Why?_____

**Status:** No Need = N Refused = R New Need = A*
* New needs require the completion of the service plan on page 2.

| NEED | STATUS | COMMENTS |
|---|---|---|
| **Health Insurance** | | |
| **Primary Care Physician** | | |
| **Preventive Health Care and Immunizations** | | |
| **Dental Care** | | |
| **Medical Care** | | |
| **Developmental** | | |
| **Educational** | | |
| **Nutritional** | | |
| **Financial** | | |
| **Housing** | | |
| **Transportation** | | |
| **Legal** | | |
| **Psychosocial** | | |
| **Other** | | |

Plan for termination of case management? Yes_____ No_____

Reasons_____

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**SERVICE PLAN FOR NEW NEEDS**

Priority: 1=Immediate 2=Intermediate 3=Long Term

**— Client/Family Need:** _____

**Service goal**: _____

| Date | Plan | By Whom | Priority | When | Outcomes (dated) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**— Client/Family Need:** _____

**Service goal**: _____

| Date | Plan | By Whom | Priority | When | Outcomes (dated) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
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**— Client/Family Need:** _____

**Service goal**: _____

| Date | Plan | By Whom | Priority | When | Outcomes (dated) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

This plan has been completed with participation by the client/parent.

Client/Parent/Guardian signature: _____ Date: _____

Case Manager signature: _____ Date: _____

Interpreter signature (if applicable): _____ Date: _____